

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

0 2 — 0 2 3

2. STATE:

CA

3. PROGRAM IDENTIFICATION - TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID):TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

August 1, 2002 December 28, 2002

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 9 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:

a. FFY unknown \$ _____

b. FFY _____ \$ _____

8. NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D pages 15-15.2, 14.19-D page 15.3

9. NUMBER OF THE SUPERSEDED PLAN SECTION OR
ATTACHMENT (If Applicable): Attachment 14.9-D
page 15-15.2, none-new page

10. SUBJECT OF AMENDMENT:

2002-03 Subacute Rate Freeze

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED:The Governor's Office does not wish to
review State Plan Amendments

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Gail L. Margolis

14. TITLE:

Esq., Deputy Director

15. DATE SUBMITTED:

FAXED 12-31-02

MAILED 1-03-03

16. RETURN TO:

Department of Health Services
Attn: State Plan Coordinator
714 P Street, Room 1640
Sacramento, CA 95814

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

1/3/03

18. DATE APPROVED

3/17/03

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

12/28/02

20. SIGNATURE OF REGIONAL OFFICIAL:

Dana Smith

21. TYPED NAME:

Charlene Brown

22. TITLE:

Deputy Director, PKSO

23. REMARKS

P & I change to effective date authorized by State on
March 10, 2003 in 2nd.

9. ICF/DDs (except state operated facilities), ICF/DD-H and ICF/DD-N facilities will be reimbursed at the 65th percentile, instead of the median, in recognition of the fact that they serve a disproportionate share of low income patients with special needs.
10. Subacute services which are provided in both distinct parts of acute care hospitals and freestanding NFs shall be reimbursed at the lesser of costs as projected by the Department or the prospective class median rate, broken down by ventilator and non-ventilator and DP or freestanding NF.
11. The subacute rate includes additional ancillary costs. Where available, the facility's projected cost is based on the audited ancillary cost data. In the event that audited ancillary costs are not available, the facility's projected cost is based on the median of the projected subacute ancillary costs of the facilities in the study that have audited ancillary costs.
12. For purposes of setting the DP/NF or subacute prospective class median rate, the Department shall use the facility's interim projected reimbursement rate when their audit report is not issued as of July 1st.
13. For the rate year 2002-03, a facility experiencing a reduction in costs, which would result in a reduced subacute reimbursement rate for the 2002-03 rate year, will have its subacute prospective reimbursement rate for 2002-03 set at its 2001-02 rate. The facility's 2002-03 subacute prospective reimbursement rate will be no more than the 2002-03 prospective class median rate determined under subparagraph 12 or the facility's Medicare upper payment limit, whichever is lower. This subparagraph shall not apply to facilities with an interim rate established pursuant to Section IV.H of this Attachment.
14. Each year the current rate for NF-A 100+ bedsize will be increased by the same percentage of increase received by other NF-level As. The term percentage increase means the average increase, weighted by patient days.
15. (a) Nursing facilities and other specified facilities as identified in Section 14110.65 of the Welfare and Institutions Code, will be eligible to request and receive a supplemental rate adjustment when the facility meets specific requirements.

(b) In order to qualify for the rate adjustment, the facility must have a verifiable written collective bargaining agreement or other

legally binding, written commitment to increase non-managerial, non-administrative and non-contract salaries, wages and/or benefits that complies with Section 14110.65 of the Welfare and Institutions Code and regulations adopted pursuant thereto.

(c) Except as provided in subparagraph (d) below, the rate adjustment will be equal to the Medi-Cal portion (based on the proportion of Medi-Cal paid days) of the total amount of any increase in salaries, wages and benefits provided in the enforceable written agreement referenced in subparagraph (b). This amount will be reduced by an increase, if any, provided to that facility during that rate year in the standardized rate methodology for labor related costs (see Section I.E of this state plan) attributable to the employees covered by the commitment. A rate adjustment made to a particular facility pursuant to this subparagraph 15 will only be paid for the period of the non-expired, enforceable, written agreement. The Department will terminate the rate adjustment for a specific facility if it finds the binding written commitment has expired and does not otherwise remain enforceable.

(d) A rate adjustment under this subparagraph 15 will be no more than the greater of 8 percent of that portion of the facility's per diem labor costs, prior to the particular rate year (August 1st through July 31st), attributable to employees covered by the written commitment, or 8 percent of the per diem labor costs of the peer group to which the facility belongs, multiplied by the percentage of the facility's per diem labor costs attributable to employees covered by the written commitment.

(e) The payment of the rate adjustment will be subject to certification of the availability of funds by the State Department of Finance by May 15 of each year and subject to appropriation of such funds in the State's Budget Act.

(f) This subparagraph 15 will become effective as of the first day of the month following the date that this provision is approved by the Centers for Medicare and Medicaid Services.

- G. Notwithstanding paragraphs A through E of this Section, prospective rates for newly licensed DP/NF-Bs shall be based on the facility's historical costs of providing NF-B services regardless of ownership or licensure.

For DP/NF-Bs with historical costs as a licensed freestanding NF-B, the Department shall establish a prospective DP/NF-B rate based on the freestanding NF-B cost report. If the newly licensed DP/NF-B has reported costs as both a freestanding NF-B and DP/NF-B, the Department

shall establish the facility's historical-costs basis by combining the freestanding NF-B and DP/NF-B total patient days and costs. Newly licensed DP/NF-Bs shall receive prospective rates based on available freestanding NF-B cost reports until the Department uses the consolidated hospital DP/NF-B cost report and/or audit in the appropriate rate study.

Newly licensed DP/NF-Bs without historical costs of providing NF-B services shall receive an interim reimbursement rate. This interim rate shall be based on the DP/NF-B's projection of their total patient days and costs, as approved by the Department. When actual DP/NF-B audit report data becomes available, interim rates will be retroactively adjusted to the DP/NF-Bs final prospective rate. Final DP/NF-B rates may be less than the interim rate, in which case the Department shall recover any overpayment.

- H. Subacute providers that do not have historical costs shall receive an interim reimbursement rate. This interim rate shall be based on the subacute facility's projection of their total patient days and costs, as approved by the Department. When actual subacute audit report data becomes available, interim rates will be retroactively adjusted to the subacute facility's final prospective rate. Final rates may be less than the interim rate, in which case the Department shall recover any overpayment. Only subacute providers participating in the program as of June 1st will be included in the rate study.

V. DETERMINATION OF RATES FOR NEW OR REVISED PROGRAMS

- A. When the State adopts a new service or significantly revises an existing service, the rate of reimbursement shall be based upon comparable and appropriate cost information which is available. Comparable rate and cost data shall be selected and combined in such a manner that the rate is reasonably expected to approximate median audited facility costs, had accurate cost reports been available for the particular class of facility. Such factors as mandated staffing levels and salary levels in comparable facilities shall be taken into account. This method of rate-setting shall ordinarily be relied upon to set rates only until such time as accurate cost reports which are representative of ongoing operations become available.
- B. When it is determined that cost report data from a class of facilities is not reliable for rate-setting purposes due to inaccuracies or reporting errors, a random sample of such facilities shall be selected for audit and the resulting audited costs shall be used for the rate study.
- C. After five years from the end of the fiscal year in which a facility begins participating in a program for Medi-Cal reimbursement, the reimbursement rate methodology will either revert to the provisions

described in Section I through IV of Attachment 4.19-D or be subject to new provisions as described in a State Plan amendment.